# LEGISLATIVE SERVICES AGENCY
## OFFICE OF FISCAL AND MANAGEMENT ANALYSIS

301 State House
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## FISCAL IMPACT STATEMENT

**LS 6746** **DATE PREPARED:** Jan 28, 2002
**BILL NUMBER:** SB 304 **BILL AMENDED:**

**SUBJECT:** Emergency Room Services.

**FISCAL ANALYST:** Kathy Norris
**PHONE NUMBER:** 234-1360

**FUNDS AFFECTED:** X **GENERAL** **IMPACT:** State
**DEDICATED**
X **FEDERAL**

**Summary of Legislation:** This bill requires that certain physician services provided in a hospital emergency department to a patient enrolled in the Medicaid Risk-Based Managed Care program by a physician who does not have a contract with the patient's managed care organization must be paid at 100% of the rates payable under the Medicaid fee structure. (The introduced version of this bill was prepared by the Joint Commission on Medicaid Oversight.)

**Effective Date:** July 1, 2002.

**Explanation of State Expenditures:** (Revised) The provision requiring 100% Medicaid fee-for-service reimbursement for out-of-network providers rendering emergency services to Risk-Based Managed Care recipients is included in IC 12-15-12-18 as passed in P.L.223-2001. This bill would require the Medicaid managed care organizations (MCO's) to pay 100% Medicaid fee-for-service reimbursement rates for all services rendered in an emergency room whether or not those services meet the definition of what a prudent layperson would consider to be an emergency.

Medicaid reports that two of the MCOs currently pay a $15 triage fee to emergency rooms for screening non-emergency MCO-enrolled recipients. The third MCO reviews these claims and denies payment if, according to the medical record, the emergency room encounter did not meet the prudent layperson's standard of an emergency medical condition. This denial of payment includes payment for a screening exam and any other services. (Non-emergency use of emergency room services is not a covered service.) Non-covered services can be billed to the MCO recipient, however, it can be difficult to actually collect the payment from a Medicaid recipient.

This bill has two payment issues: first is the payment for the required screening exams. Medicaid reports that screening exams performed on MCO recipients who present themselves at an emergency room with a condition that meets the "prudent layperson standard" of an emergency condition are paid at 100% of the

Medicaid fee- for-service reimbursement. The MCO contracts require that out-of-network providers must be paid at 100% of the fee-for-service rate. Two of the MCOs have decided to pay a triage fee for examinations of individuals who seek emergency services for non-emergency conditions. The third MCO denies payment for all inappropriate use of ER services after a medical record review. Medicaid reports that the bill would require all the MCOs to pay for all screening or triage at 100% of the fee-for-service reimbursement regardless of whether the patient believed there was an emergency condition or not. Financially this requirement would impact the three MCOs differently depending on if the organization is currently paying a triage fee or denying the claims in total.

The second requirement is that the MCOs pay for all physician services provided by out-of-network providers in emergency rooms at 100% of Medicaid fee-for-service reimbursement. Medicaid managed care operates under a federally approved waiver. The rule waived is the recipient's freedom of choice. MCO recipients select or are assigned a primary care provider to give the individual a "medical care home". The primary care provider is then responsible for that recipient's preventative and routine care. Controlling inappropriate use of emergency room services is one of the methods that MCOs use to control costs within the network. Requiring payment for all services rendered in an emergency room encourages recipients to continue to seek care in an inappropriate setting and interferes with the ability of the MCO to control costs. Ideally in the managed care model, patients presenting in an emergency room for routine care should be referred to their primary care physician.

The payments would occur within the capitated managed care contracts. Increased costs to the state could occur to the extent that increased risk-based managed care costs were passed through the negotiated rates.

**Explanation of State Revenues:** The Medicaid program expenditures are reimbursed at 62% of the total by the federal government; the state share is 38%.

**Explanation of Local Expenditures:**

**Explanation of Local Revenues:**

**State Agencies Affected:** Family and Social Services Administration, Office of Medicaid Policy and Planning.

**Local Agencies Affected:**

**Information Sources:** Amy Brown, Legislative liaison for Family and Social Services Administration, (317) 232-1149.